The latter factors cause a reduction of cerebral blood perfusion. The psychomotoradaptation syndrome requires multidisciplinary management including medical, physiotherapeutic and psychological approaches.

Early specific rehabilitation is determining factors for prognosis. The rehabilitation program must be global and linked with the objectives of life and the residual motivation of the patient. Techniques are numerous and adapted to every person. The priority objective is learning of basic motor patterns (rolling in the bed, sit to stand and sit to stand to sit). The correction of the retropulsion is used always during the rehabilitation in the learning of basic acts.

Sarcopecty is defined by loss of muscular mass, strength and quality that occurs in elderly. It has become an important area of research because of its frequency and its responsibility for a significant part of the mobility disability in older people. Understanding and treating sarcopenia could probably have a dramatic impact on the disability process.

A definitive consensual clinical method to assess sarcopenia is still needed in everyday clinical practice and clinical research. The different characteristics that define sarcopenia are usually studied separately. The loss of muscular mass and muscle strength is mainly caused by low physical activity, aged-related changes in steroids hormones and inflammatory processes. Treatment relies on a multidimensional approach. Preventing loss of muscular mass and preserving muscle strength is relevant if it prevents decline in physical performance and mobility disability. Identifying target elderly populations for preserving muscle strength is relevant if it prevents decline in physical performance and mobility disability. Understanding and treating sarcopenia could probably have a dramatic impact on the disability process.

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Spatial-temporal gait analysis in Normal pressure hydrocephalus and Parkinson’s disease

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Introduction.– The spatial-temporal gait disorders associated with normal pressure hydrocephalus (NPH) [1] and Parkinson’s disease (PD) [2] are classically considered difficult to distinguish from each other clinically.

Methods.– Three age-matched groups participated in this study: subjects with idiopathic NPH (n = 12, 68 ± 12 years), subjects with early to moderate PD (n = 25, 69 ± 8 years, Hoehn & Yahr 2–3, OFF) and control subjects (CTL, n = 14, 66 ± 12 years). Each subject walked 8 m barefoot on a baropodometric carpet (GaitRiteTM), at free and fast speed. We analyzed speed, cadence, step length and width, a cadence index (CDI) and step length index (SLI) that represent the relative contribution of each parameter to speed increase, as follows:

CDI = log(CDfast/CDfree)/log(SPfast/SPfree) × 100
SLI = log(SLfast/SLfree)/log(SPfast/SPfree) × 100

Results.– Free speed

The NPH group was slower than normal (CTL, 1.07 ± 0.21 m/s, NPH, 0.73 ± 0.28 m/s, P = 0.022) with increased step width (CTL, 0.10 ± 0.04 m, NPH, 0.13 ± 0.05 m, P = 0.049). In the PD group, cadence was abnormally